APPENDIX C

Recommendation/Content Summary from Appendix E House Document 23

YEAR	TITLE	PRIMARY AUTHOR	TOPIC ADDRESSED AND/OR RECOMMENDATIONS
1988	Investing in Virginia's Future: A Continuum of Care for our Adolescents at Risk	Interagency Conference Proceedings, DMHMRSAS	A memorandum of agreement by the Secretariats and department heads and in interagency budget initiative for the 1988-1990 Biennium. The agreement created an Interagency Funds Pool to help localities meet the needs of Seriously Emotionally Disturbed (SED) children and criteria for eligibility of funding.
1991	Improving Care for Trouble and At-Risk Youth and Their Families	The Council on Community Services for Youth and Families	Set forth the plan for what is now known as the Comprehensive Services Act for At-Risk Youth and Families. This report included: 1) Preliminary findings from the demonstration projects; 2) A long-range plan for phasing in community-based nonresidential services across the Commonwealth; 3) An interagency plan for redirecting current funds and identifying new revenue resources for funding community-based services, including consideration of Medicaid; and 4) Any proposed legislation necessary for implementation.
1989	The Invisible Children's Project	Mental Health Association of Virginia	1) Treatment and care should be through a comprehensive array of services that is community-based and family focused; 2) There should be collaboration in all planning, funding, and implementation strategies; 3) Early identification and intervention 4) Use of a case manager for each child 5) Recognition of the special needs of families of children with multiple disabilities; 6) The needs of the child and family should dictate the types and mix of services provided with families as full participants in service planning and delivery; 7) There should be effective advocacy and protection of rights for emotionally disturbed children; 8) Services for children and their families should be available within the least restrictive, most normalizing environment that is clinically appropriate; and 9) Services should be provided without regard to race, religion, etc. and should be sensitive to cultural differences.
1990	A Study of	Virginia	1) The current service delivery system for

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	Children's Residential Services	Department of Planning and Budget	children with emotional and behavioral problems and their families requires significant change in order to be consistent with the goals of family preservation, individualized services in the least restrictive setting; 2) Expenditures of children in residential care should be tracked, in an effort to control costs and an interagency tracking and reporting system should be developed; 3) Consolidation of funds in social services and juvenile justices systems used for residential placements; 4) Funding of residential placements should be shared by the placing locality; 5) Other sources of funding for children's services needs to be explored; 6) Community-based services for children and their families need to be expanded; 7) DMHMRSAS should prioritize services for those children at imminent risk of residential placement by other agencies; 8) State funds saved from increased usage of community based options should be reinvested in developing increase community-based services capacities; and 9) DSS, DMHMRSAS, DSS and DOE should develop a process to evaluate the appropriateness and effectiveness of selected residential placements.
1990	Community Service Model for Troubled Children and Their Families in Virginia	The Council on Community Services for Youth and Families	Selected findings: 1) Children and their families are best served by a system that is comprehensive, coordinated, and responsive to needs; 2) Each child's service program has to be tailored to his/her individual needs rather than attempting to fit the child into a pre-structured program; 3) Comprehensive care in conjunction with early recognition and preventative care; 4) Available resources and funding should be pooled; 5) Communities are diverse and faced with needs and problems with varying levels and types of resources available to youth; and 6) Localities should be able to choose from an array of core services to meet the local needs of youth and their families.

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1992	Virginia Child and Adolescent Service System Program (CASSP) Demonstration Project	DMHMRSAS	Sought to: 1) Identify and empower constituencies of advocates, parents, families, consumers, and providers to promote and guide state level system development for children and adolescents; 2) Promote interagency coordination in the planning, funding and delivery of services to SED children and adolescents; 3) Develop a responsive service system for SED children and adolescents that includes those services necessary to effectively meet their complex needs; and 4) Provide training to community services boards and local interagency service projects to ensure community-based service development and implementation are guided by state-of-the-art knowledge.
1992	The Council on Community Services for Youth and Families Demonstration Projects: Technical Report on Evaluation	Commonwealth Institute for Child and Family Studies	Selected findings of demonstration projects conducted to identify how to improve services and control costs: 1) Youth in demonstration projects were significantly less likely to be placed in a residential setting; 2) Youth in the demonstration projects were significantly more likely to have received advocacy, case management, financial assistance, in-home services, and transportation services; 3) Interagency teams were central to the projects, and in all cases, the teams were expanded either in number of participants or frequency of meetings; 4) The availability of more resources and local service alternatives was a major positive outcome expressed by local personnel; 5) Changes in structure were seen as positive, but concern expressed over increased staff time demands attending meetings and staffing of cases; 6) Responses to consumer satisfaction questionnaires were consistently positive; and 7) Data suggested that on average, the use of residential care changed very little.
1994	Comprehensive Services for At-Risk Youth and Families:	DMHMRSAS	New Services Developed: 1) Intensive probation 2) Therapeutic Respite Care

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	Demonstration Projects SFY '93 Evaluation Report		3) Parent and Student Aide Programs 4) Day Treatment Programs 5) After School Programs 6) Therapeutic Summer Programs 7) Pre-school Prevention Programs 8) Transition Classrooms Major Explorations: 1) Who are the youth being served by the Demonstration Projects?; 2) What evidence is there of increased identification and intervention with younger children at risk of developing emotional and behavioral problems?; 3) How have the communities' capacities for providing community-based alternatives to residential services changed through the Demonstration Projects?; 4) How have local child serving agencies cooperated and collaborated in the planning and provision of services to youth with SED and behavioral problems?; 5) How satisfied are the youth, families and service providers with the services being received through the project?; 6) To what extent has the use of residential services changed as indicated by the number of youth placed out of the home and the expenditures for those services?; and 7) To what extent have the youth served changed as the result of services received through the Demonstration Projects?
1994	The Impact of the Downsizing of Virginia's State Psychiatric Hospitals for Children Without Increased Community Care Options	Community Services Board Planning Committee	Selected findings: 1) Each CSB should have or be able to purchase a flexible array of eight basic services; 2) Capacity of the CSBs to provide these eight foundation services needs to be expanded as needed in that locality; and 3) To provide the needed services, the estimated increase in funding needed is $47.830,600.00.
1994/5	Comprehensive Services Act Implementation Assessment	Research and Evaluation Center of the DMHMRSAS	Recommendations: 1) Improve information available to decision makers through the development of a CSA Management Information System; 2) Provide incentives and/or assistance to localities to develop community-based

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			services which foster family preservation and cost savings; 3) Identify and correct financial disincentives which may encourage localities to utilize out-of-home placements, instead of community-based services; 4) Explore potential mechanisms by which non-mandated youth could have adequate access to CSA services, and project costs to the state and localities; 5) As recommended by the CSA Forecasting Task Force, request the Department of Planning and Budget re-establish the technical forecasting group to project the future demand for CSA services and their associated costs; 6) Continue state financial assistance to localities for CSA administration; and 7) Create or find ways to reduce the local administrative burden. 8) Identify specific problems CSA teams may encounter with local courts and aggressively seek solutions; 9) Continue to monitor the capacity of Family Assessment and Planning Teams to engage parents to participate in service planning and implementation; 10) Establish more formal private/public partnerships to lay the groundwork and provide incentives for developing a full array of children's services consistent with the intentions of CSA; 11) Request the DPB repeat its study of private provider fees; 12) Publicly recognize local CSA participants for their accomplishments in making CSA a reality; 13) Request that the State Executive Council (SEC) assume responsibility for the coordination of prevention/early intervention activities within the framework of CSA; 14) Publicize Virginia's experiences with CSA.
1995	Non-Mandated Youth: History and Potential Fiscal Approaches	State Management Team	1) A large number of localities are not using the protection provided by the SEC to assure that some non-mandated youth in their locality receive services;

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			2) There is a decreasing reliance on residential and private service, suggesting that community efforts to build capacity may be realized; 3) There is mixed success regarding the CSA non-mandated funds; 4) Two distinct types of spending patterns are exhibited by localities: "Want more" and "Don't spend"; 5) Any approach to resolve funding issues must address both types of patterns in order to create improvements on a statewide basis;
1995	Evaluation of the Comprehensive Services Act	Secretary of Health and Human Resources, Secretary of Public Safety, and the Secretary of Education	1) Implementing CSA is costly in terms of staff time, administrative support, and actual expenses; 2) Most localities believe that CSA is meeting its goals of stronger interagency collaboration and family participation; and 3) Non-mandated children do not receive the services they need.
1998	Review of the Comprehensive Services Act	Joint Legislative Audit and Review Commission	1) The General Assembly may wish to require that the SEC develop a mandatory uniform assessment instrument process to be used by all localities that identifies the appropriate level of care for various levels of risk; 2) The General Assembly may wish to require all cases for which treatment services (not foster care maintenance) are requested to appear before a multi-agency team at the locality; 3) The General Assembly may wish to require the Department of Medical Assistance Services to amend its state plan to include Medicaid payment for residential care and therapeutic foster care; and 4) The General Assembly may wish to require that non-mandated cases where children have displayed acute or recent risk by afforded sum-sufficient funding.
1998	A Study of Service for Children Who are Not Included in the Mandated Populations of the Comprehensive Services Act for At-	The Office of the Executive Secretary, Supreme Court of Virginia: Under the direction of the Comprehensive	1) Further study needs to be done; 2) Further inquiry could comprehensively distinguish existing services and funding source and, most importantly, identify gaps in these areas; and 3) Examination of these issues should be undertaken by of the Secretaries of

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	Risk Youth and Families	Services Act State Executive Council	Education, Health and Human Resources, and Public Safety. A broad-based policy review is required, not unlike the original effort that resulted in the development of legislation and policy for the CSA.
1999	Educational Needs of Emotionally Disturbed Students with Visual and Hearing Impairments	Department of Education and the Disability Commission	1) Adopt a Massachusetts program for use at the Virginia School for the Deaf and Blind; and 2) Creation of a program on the campus of the residential school so it is in the community and among educators/residential specialists who have experience working with the deaf and blind population.
1999	Continuum of Care for Children and Adolescents	Child and Family Task Force of the Virginia Association of Community Service Boards (VACSB)	Services that, on a nationally recognized idea of a system of care, comprise what is thought of as a "system of care" for children and adolescents: 1) Family Support 2) Crisis Intervention 3) Case Management 4) Outpatient 5) Intensive Community Based Treatment 6) Specialized Vocational Programs; and 7) Community-Based Residential Programs
1999	Keeping Our Kids at Home(KOKAH) Project: A Study of the Feasibility, Efficacy, and Cost-Effectiveness of Expanding the Project Statewide	DMHMRSAS	1) A model of KOKAH should be implemented in each of the Health Planning Regions of the state; 2) The KOKAH model should be modified to include less reliance on local inpatient hospitalization, a broader array of community-based and step down services, and standards for hospital utilization rates; 3) A grant of flexible dollars should be given to each site, to purchase or implement an array of services, with an emphasis on community-based treatment—including the purchase of local inpatient treatment; and 4) The development of a standardized risk assessment and clinical guidelines to support decision-making regarding the use of local private facilities and state inpatient facilities.
1999	Virginia's Continuing Policy to Take Away State Psychiatric Hospitals for Children Without	Child and Family Services Council of the Virginia Association of Community Service Boards	1) Sufficient funding for community service development has been shown to reduce the number of hospitalizations of children, who could benefit from less restrictive, but very intensive services; 2) Transfer state funds to develop services

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	Increasing Community Service Options		close to communities; 3) The funds saved from downsizing institutional care should be made available to the community to provide follow-up care; and 4) Virginia must begin to plan services for children and adolescents, and should include in its comprehensive planning families, advocates, community service providers and the DMHMRSAS.
2000	Report of the Joint Subcommittee to Evaluate the Future Delivery of Publicly Funded Mental Health, Mental Retardation and Substance Abuse Services: A Report to the Governor	House Document 101, 2000 General Assembly Session	A feasibility study examining the impact of a carve-out of Medicaid financed mental health, mental retardation and substance abuse services from any managed care contracts negotiated with HMOs, and of contracting out the administration of all Medicaid-covered mental health, mental retardation, and substance abuse services to DMHMRSAS. 1) CSBs to function as care coordinators, and as the single point of entry into the services system. Care coordination is the central service function of CSBs in a managed system of care, and it would be provided exclusively by the CSBs and behavioral health authorities; and 2) The Chair of the State Executive Council, supported by the Office of Comprehensive Services, shall examine the potential for the use of the underutilized state property under the control of the DMHMRSAS to determine if the use of this property, if leased to vendors, would reduce the cost of services in the provision under the CSA. Every attempt should be made to locate these treatment facilities, if deemed feasible, in an appropriate geographic distribution across the state that allows children and families to have reasonable access to services.